

# ATTACHMENT 6

## Sample Prior Authorization Request Form (PA/RF) for audiology services

DEPARTMENT OF HEALTH AND FAMILY SERVICES  
Division of Health Care Financing  
HCF 11018 (Rev. 06/03)

STATE OF WISCONSIN  
HFS 106.03(4), Wis. Admin. Code

### WISCONSIN MEDICAID PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read your service-specific Prior Authorization Request Form (PA/RF) Completion Instructions.

<b>FOR MEDICAID USE ?</b> ICN	AT	Prior Authorization Number
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#### SECTION I — PROVIDER INFORMATION

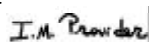
1. Name and Address — Billing Provider (Street, City, State, Zip Code)  I.M. Billing 500 Willow St Anytown, WI 55555	2. Telephone Number ? Billing Provider (XXX) XXX-XXXX  4. Billing Provider's Medicaid Provider Number 87654321	3. Processing Type  113
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#### SECTION II — RECIPIENT INFORMATION

5. Recipient Medicaid ID Number 1234567890	6. Date of Birth — Recipient (MM/DD/YY) (MM/DD/YY)	7. Address — Recipient (Street, City, State, Zip Code) 609 Willow St Anytown, WI 55555
8. Name — Recipient (Last, First, Middle Initial) Recipient, Im A.		9. Sex — Recipient <input type="checkbox"/> M <input checked="" type="checkbox"/> F

#### SECTION III — DIAGNOSIS / TREATMENT INFORMATION

10. Diagnosis — Primary Code and Description 389.10 Sensorineural Hearing Loss, Unspecified		11. Start Date — SOI	12. First Date of Treatment — SOI			
13. Diagnosis — Secondary Code and Description		14. Requested Start Date				
15. Performing Provider Number	16. Procedure Code	17. Modifiers 1 2 3 4	18. POS	19. Description of Service	20. QR	21. Charge
	92506		11	Evaluation of Speech and Language	1	XX.XX
	92507		11	Aural Rehabilitation	6	XX.XX
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after the authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid HMO at the time a prior authorized service is provided, Medicaid reimbursement will be allowed only if the service is not covered by the HMO.					22. Total Charges	XXX.XX

23. SIGNATURE — Requesting Provider 	24. Date Signed MM/DD/YY
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<b>FOR MEDICAID USE</b>	Procedure(s) Authorized:	Quantity Authorized:
<input type="checkbox"/> Approved  Grant Date _____ Expiration Date _____		
<input type="checkbox"/> Modified — Reason:		
<input type="checkbox"/> Denied — Reason:		
<input type="checkbox"/> Returned — Reason:		
SIGNATURE — Consultant / Analyst _____		Date Signed _____